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# 2001 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2001)

#### IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.		39586	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER				
	Facility Name:         NATURE TRAIL HEALTHCARE CENTER           Address:         1001 South 34th Street         Mt. Vernon           Number         City           County:         Jefferson           Telephone Number:         (618) 242-5700         Fax # (618) 242-5705		62864 Zip Code	I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.			
	IDPA ID Number: 381923423001				ational misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment.		
	Date of Initial License for Current Owners:  Type of Ownership:	06/07/94		Officer or	(Signed) (Date) (Type or Print Name) LINDA HOLTZSCHEITER		
	VOLUNTARY,NON-PROFIT Charitable Corp.	X PROPRIETARY Individual	GOVERNMENTAL State		(Title) REIMBURSEMENT MANAGER		
	Trust IRS Exemption Code	Partnership Corporation	County Other		(Signed) (Date)		
		"Sub-S" Corp. Limited Liability Co. Trust		Preparer	(Print Name and Title) Cathy Simeoni  Manager - Healthcare Consulting		
		Other			(Firm Name Kellogg & Andelson, Accountancy Corporation & Address)  16162 Beach Blvd, #308, Huntington Beach, CA 92647		
	In the event there are further questions about this report, please contact: Name: Cathy Simeoni Telephone Number: (714) 596-7713, Ext 12				(Telephone)		

STATE OF ILLINOIS Page 2

Facility Name & ID Numb	er NATURE TRAIL HEAL	LTHCARE CENTER			# 0039586 Report Period Beginning: 1/1/01 Ending: 12/31/01
III. STATISTICA	L DATA				D. How many bed-hold days during this year were paid by Public Aid?
A. Licensure/c	ertification level(s) of care; ente	r number of beds/bed days,			(Do not include bed-hold days in Section B.)
(must agree	with license). Date of change in l	icensed beds		_	
					E. List all services provided by your facility for non-patients.
1	2	3	4		(E.g., day care, "meals on wheels", outpatient therapy)
					NONE
Beds at			Licensed		
Beginning of	Licensure	Beds at End of	<b>Bed Days During</b>		F. Does the facility maintain a daily midnight census? YES
Report Period	Level of Care	Report Period	Report Period		
					G. Do pages 3 & 4 include expenses for services or
1	Skilled (SNF)			1	investments not directly related to patient care?
2	Skilled Pediatric (SNF/PED)			2	YES X NO
3 74	Intermediate (ICF)	74	27,010	3	
4	Intermediate/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	Sheltered Care (SC)			5	YES NO X
6	ICF/DD 16 or Less			6	I On what data did you start providing long town care at this location?
7 74	TOTALS	74	27,010	7	I. On what date did you start providing long term care at this location?  Date started 06/07/94
7 74	IOTALS	/4	27,010	/	Date started 00/07/94
					J. Was the facility purchased or leased after January 1, 1978?
B. Census-For	the entire report period.				YES X Date 06/07/94 NO
1	2 3	4	5		
Level of Care	-	f Care and Primary Source of	-		K. Was the facility certified for Medicare during the reporting year?
	Public Aid	Source of		1	YES NO X If YES, enter number
	Recipient Private	Pay Other	Total		of beds certified and days of care provided
8 SNF	•			8	<del></del> · · · <del></del>
9 SNF/PED				9	Medicare Intermediary
10 ICF	19,558	3,185	22,743	10	
11 ICF/DD				11	IV. ACCOUNTING BASIS
12 SC				12	MODIFIED
13 DD 16 OR LESS				13	ACCRUAL X CASH* CASH*
14 TOTALS	19,558	3,185	22,743	14	Is your fiscal year identical to your tax year? YES X NO
	cupancy. (Column 5, line 14 divi	ded by total licensed 84.20%		Tax Year: 12/31/01 Fiscal Year: 12/31/01 * All facilities other than governmental must report on the accrual basis.	

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Page 3 12/31/01 Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER # 0039586 **Report Period Beginning:** 1/1/01 **Ending:** 

	V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)											
			osts Per Genera	- 0		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	116,325	7,889	4,128	128,342		128,342	(3,242)	125,100			1
2	Food Purchase		82,594		82,594		82,594		82,594			2
3	Housekeeping	49,583	6,778		56,361		56,361		56,361			3
4	Laundry	30,521	5,130		35,651		35,651		35,651			4
5	Heat and Other Utilities			56,550	56,550		56,550	195	56,745			5
6	Maintenance	27,484	17,231	12,933	57,648		57,648	92	57,740			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	223,913	119,622	73,611	417,146		417,146	(2,955)	414,191			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	611,241	21,599	4,504	637,344		637,344	6,732	644,076			10
10a	Therapy		692		692		692		692			10a
11	Activities	28,204	2,099	1,137	31,440		31,440		31,440			11
12	Social Services	20,223		1,617	21,840		21,840		21,840			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	659,668	24,390	13,258	697,316		697,316	6,732	704,048			16
	C. General Administration											
17		57,619			57,619		57,619		57,619			17
18	Directors Fees											18
19	Professional Services			793	793		793	1,929	2,722			19
20	Dues, Fees, Subscriptions & Promotions			4,406	4,406		4,406	60	4,466			20
21	Clerical & General Office Expenses	52,749	5,219	78,521	136,489		136,489	66,654	203,143			21
22	Employee Benefits & Payroll Taxes			179,261	179,261		179,261		179,261			22
23	Inservice Training & Education			116	116		116		116			23
24	Travel and Seminar			9,057	9,057		9,057	6,003	15,060			24
25	Other Admin. Staff Transportation				İ							25
26	Insurance-Prop.Liab.Malpractice			52,587	52,587		52,587	(27,088)	25,499			26
27	Other (specify):*											27
28	TOTAL General Administration	110,368	5,219	324,741	440,328		440,328	47,558	487,886			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	993,949	149,231	411,610	1,554,790		1,554,790	51,335	1,606,125			29

\*\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

NATURE TRAIL HEALTHCARE CENTER

#0039586

**Report Period Beginning:** 

1/1/01 **Ending:** 

Page 4 12/31/01

# V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted FOR OHF USE OF		USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	r			60,579	60,579		60,579	65,503	126,082			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			19,878	19,878		19,878		19,878			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* SEE PG 4.2							9,883	9,883			36
37	TOTAL Ownership			80,457	80,457		80,457	75,386	155,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,597	8,593	11,190		11,190		11,190			39
40	Barber and Beauty Shops			6,963	6,963		6,963	(6,963)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		2,597	56,071	58,668		58,668	(6,963)	51,705	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	993,949	151,828	548,138	1,693,915		1,693,915	119,758	1,813,673			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

# 0039586

**Report Period Beginning:** A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

nn 2 below. reference the line on which the particular cost was included. (See instructions.)

	In column	2 below, i	eference the	ine on w	hich the particu	lar cos
	NON-ALLOWABLE EXPENSES		1 Amount	2 Refer- ence	OHF USE ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals		(3,242)	1		4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation					9
10	Interest and Other Investment Income					10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax					13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties					18
19	Entertainment					19
20	Contributions					20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt		40,705	21		24
25	Fund Raising, Advertising and Promotional					25
	Income Taxes and Illinois Personal					
26	Property Replacement Tax					26
	Nurse Aide Training for Non-Employees					27
28	Yellow Page Advertising					28
29	Other-Attach Schedule		2,816			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	40,279		\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

1	_	
Amount	Reference	
\$		31
		32
		33
70.470		24

31 Non-Paid Workers-Attach Schedule\* 32 Donated Goods-Attach Schedule\* Amortization of Organization & **33** Pre-Operating Expense Adjustments for Related Organization 34 Costs (Schedule VII) 79,479 35 Other- Attach Schedule 35 36 SUBTOTAL (B): (sum of lines 31-35) 79,479 36 (sum of SUBTOTALS 37 TOTAL ADJUSTMENTS (A) and (B) 119,758 37

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(Se	e instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

# NATURE TRAIL HEALTHCARE CENTER

Sch. V Line

Page 5A

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1	Sales Taxes	\$ (1,376	21	1
2	Open House Expense	(365		2
3	FAS 121**	83,070		3
4	Barber & Beauty	(6,963	40	4
5	Professional Liability Insurance	(25,872	26	5
6	Depreciation Reconciliation	(17,567	30	6
7	Marketing Salary	(28,111	) 21	7
8				8
9				9
10	**The facility re-valued their assets in 1999. We			10
11	have reported the historical costs of the assets			11
12	consistent with the prior years, and have ensured			12
13	that depreciation expense is reported on straight			13
14	line. This adjustment is necessary to reverse the			14
15	re-valuation of historical cost.			15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,816	i	49
	L	•		•

Summary A Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER
SUMMARY OF PAGES 5. 5A, 6. 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I # 0039586 Report Period Beginning: 1/1/01 12/31/01 **Ending:** 

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D, 0	6E, 6F, 6G, 61	H AND 6I										
													SUMMARY	l
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	l
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	<b>6I</b>	(to Sch V, col	.7)
1	Dietary	(3,242)	0	0	0	0	0	0	0	0	0	0	(3,242)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	195	0	0	0	0	0	0	0	0	0	195	5
6	Maintenance	0	92	0	0	0	0	0	0	0	0	0	92	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,242)	287	0	0	0	0	0	0	0	0	0	(2,955)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,732	0	0	0	0	0	0	0	0	0	6,732	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	6,732	0	0	0	0	0	0	0	0	0	6,732	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,929	0	0	0	0	0	0	0	0	0	1,929	19
20	Fees, Subscriptions & Promotions	0	60	0	0	0	0	0	0	0	0	0	60	20
21	Clerical & General Office Expenses	10,853	55,801	0	0	0	0	0	0	0	0	0	66,654	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,003	0	0	0	0	0	0	0	0	0	6,003	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(25,872)	(1,216)	0	0	0	0	0	0	0	0	0	(27,088)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(15,019)	62,577	0	0	0	0	0	0	0	0	0	47,558	28
	TOTAL Operating Expense							<del> </del>						1
29	(sum of lines 8,16 & 28)	(18,261)	69,596	0	0	0	0	0	0	0	0	0	51,335	29

Summary B Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER # 0039586 Report Period Beginning: 1/1/01 Ending: 12/31/01

# SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 <b>G</b>	6H	6I	(to Sch V, col	.7)
30	Depreciation	65,503	0	0	0	0	0	0	0	0	0	0	65,503	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	9,883	0	0	0	0	0	0	0	0	0	9,883	36
37	TOTAL Ownership	65,503	9,883	0	0	0	0	0	0	0	0	0	75,386	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(6,963)	0	0	0	0	0	0	0	0	0	0	(6,963)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(6,963)	0	0	0	0	0	0	0	0	0	0	(6,963)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	40,279	79,479	0	0	0	0	0	0	0	0	0	119,758	45

79,479 \$ \*

79,479

# VII. RELATED PARTIES

14 Total

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.								
1		2	3					
OWNERS		RELATED NURSING HO	OTHER REL	OTHER RELATED BUSINESS ENTITIES				
Name	Ownership %	Name	City	Name	City	Type of Business		
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute	Atlanta, GA	Bookkeeping &		
				Network		Management		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5	Cost to Related Organization	6	7	8 Difference:	
							Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount		Name of Related Organization	of	of Related	Related Organization	
							Ownership	Organization	Costs (7 minus 4)	
1	V	5	Utilities	\$		Mariner Post Acute Network	100.00%	<b>\$</b> 195	s 195	1
2	V	6	Repairs and Maintenance			Mariner Post Acute Network	100.00%	92	92	2
3	V	19	Professional Services			Mariner Post Acute Network	100.00%	1,929	1,929	3
4	V	20	Fees, Subscriptions, Promotions			Mariner Post Acute Network	100.00%	60	60	4
5	V	10	Nursing and Medical Records			Mariner Post Acute Network	100.00%	6,732	6,732	5
6	V	21	Clerical and General Office Exp			Mariner Post Acute Network	100.00%	55,801	55,801	6
7	V	24	Travel and Seminar			Mariner Post Acute Network	100.00%	6,003	6,003	7
8	V	26	Insurance Premium			Mariner Post Acute Network	100.00%	(1,216)	(1,216)	8
9	V	36	Depreciation			Mariner Post Acute Network	100.00%	6,920	6,920	9
10	V	36	Taxes-Property			Mariner Post Acute Network	100.00%	290	290	10
11	V	36	Rental & Leasing			Mariner Post Acute Network	100.00%	1,748	1,748	11
12	V	36	Lease Expense			Mariner Post Acute Network	100.00%	924	924	12
13	V	36	Property Insurance			Mariner Post Acute Network	100.00%	1	1	13

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

Page 7 NATURE TRAIL HEALTHCARE CENTEL 0039586 **Report Period Beginning:** 1/1/01 12/31/01 Facility Name & ID Number **Ending:** 

# VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hou	ırs Per Work				
					Compensation	Week Dev	oted to this	Compensati	on Included	Schedule V.	
					Received		l % of Total	in Costs		Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4	NOT APPLICABLE										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8 # 0039586 Report Period Beginning: 1/1/01

Ending: 12/31/01

# VIII. ALLOCATION OF INDIRECT COSTS

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER

	Name of Related Organization	Mariner Post Acute Network
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	One Ravine Dr., Suite 1500
or parent organization costs? (See instructions.)  YES X  NO	City / State / Zip Code	Atlanta, GA 30346
	Phone Number	770)379-8203
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	770)399-1971

	1	2	3	4	5	6	7	8	9	$\Box$
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	5	Utilities	Facility Costs			\$ 20,767	\$		\$ 195	1
2	6	Repairs and Maintenance	Facility Costs			9,731			92	2
3		Professional Services	Facility Costs			205,127			1,929	3
4	20	Fees, Subscriptions, Promotions	Facility Costs			6,427			60	4
5	10	Nursing and Medical Records	Facility Costs			67,554			6,732	5
6		Clerical and General Office Exp	Facility Costs			6,582,242			55,801	6
7	24	Travel and Seminar	Facility Costs			638,416			6,003	7
8	26	Insurance Premium	Facility Costs			(129,286)			(1,216)	8
9	36	Depreciation	Facility Costs			735,846			6,920	9
10	36	Taxes-Property	Facility Costs			30,882			290	10
11		Rental & Leasing	Facility Costs			185,889			1,748	11
12	36	Lease Expense	Facility Costs			98,311			924	12
13	36	Property Insurance	Facility Costs			76			1	13
14										14
15										15
16										16
17										17
18										18
19										19
20				·						20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 8,451,982	\$		\$ 79,479	25

STA'	TE OF	LH 5	INOIS

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER

# 0039586 Report Period Beginning:

1/1/01

**Ending:** 

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# IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	ì	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amor Original	unt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related								9 /		
	Long-Term										
1						\$	\$			\$	1
2											2
3											3
4											4
5								ļ			5
	Working Capital			T					1		
6											6
7											7
8											8
9	TOTAL Facility Related					\$	\$			\$	9
	B. Non-Facility Related*										
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$	s			\$	14
15	TOTALS (line 9+line14)					\$	\$			\$	15

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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# 0039586 Report Period Beginning: 1/1/01 Ending: 12/31/01

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

D. Real Estate Taxes						_
Real Estate Tax accrual used on 2000 report.	<i>Important</i> , please see the next worksheet, bill must accompany the cost report.	"RE_Tax". The real	estate tax statement and	s	18,911	1
	the tax year to which this payment applies. If payment cover	ers more than one year, de	tail below.)	s	19,494	2
3. Under or (over) accrual (line 2 minus line 1).				s	583	3
4. Real Estate Tax accrual used for 2001 report. (E	tetail and explain your calculation of this accrual on the lines	s below.)		s	19,295	4
**	ch has NOT been included in professional fees or other gene copies of invoices to support the cost and a co			\$		5
6. Subtract a refund of real estate taxes. You must classified as a real estate tax cost plus one-half o	, 11	al estate tax appeal	board's decision.)	s		6
7. Real Estate Tax expense reported on Schedule V	, line 33. This should be a combination of lines 3 thru 6.			\$	19,878	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	1996 17,975 8		FOR OHF USE ONLY			T
	1997     18,818     9       1998     19,518     10	13	FROM R. E. TAX STATEMENT FOI	R 2000 \$		1
	1999     19,647     11       2000     19,494     12	14	PLUS APPEAL COST FROM LINE	5 \$		1
		15	LESS REFUND FROM LINE 6	\$		1
		16	AMOUNT TO USE FOR RATE CAL	CUI ATION \$		1

NOTES:

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
  application for real estate tax exemption unless the building is rented from a for-profit entity.
  This denial must be no more than four years old at the time the cost report is filed.

#### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

# 2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	NATURE TRAI	L HEALTHCARE CI	ENTER		COUNTY	Jefferson	
FAC	ILITY IDPH LICEN	ISE NUMBER	0039586					
CON	TACT PERSON RE	GARDING THI	S REPORT Cathy S	imeoni				
TEL	EPHONE (714)596	-7713		FAX#:	(714)596-	7721		
A.	Summary of Real	Estate Tax Cost	<u>t</u>					
	cost that applies to home property whi	the operation of the ch is vacant, rent	estate tax assessed for the nursing home in C ted to other organizati de cost for any period	Column D. Re ons, or used fo	al estate tax or purposes	c applicable to other than lon	any portion o	f the nursing
	(A)		(B)			(C)		(D)
	Tax Index N	<u>umber</u>	Property Des	cription		Total Tax		Tax Applicable to Jursing Home
1.	06-36-327-006		77-1-079-04 PT N	E SW-BEG 33		19,493.98		19,493.98
2.					-		_	
3.								
4. 5.								
5. 6.					. 3_		- }-	
7.								
8.								
9.					- \$_ \$			
10.					\$		\$	
					_			
				TOTALS	\$_	19,493.98	\$	19,493.98
B.	Real Estate Tax C	ost Allocations						
	Does any portion o used for nursing ho		ly to more than one nu YES	ursing home, v		erty, or proper	ty which is no	t directly
			chedule which shows just be allocated to the					me.

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

C. Tax Bills

Page 10A

	ity Name & ID Number NATU JILDING AND GENERAL IN				STATE O	F ILLINOIS 0039586		eriod Beginning:		1/1/01	Ending:	Page 11 12/31/01
A.	Square Feet:	17,558	B. General Construction Type:	Exterior	BRICK		Frame	STEEL	Num	ber of Sto	ries	1
C.	Does the Operating Entity? (Facilities checking (a) or (b)	<u> </u>	X (a) Own the Facility Dete Schedule XI. Those checking (	(b) Rent from				uctions.)		from Con nization.	npletely Unre	lated
D.	Does the Operating Entity? (Facilities checking (a) or (b)	1	X (a) Own the Equipment olete Schedule XI-C. Those checkin	(b) Rent equip						equipmen lated Orga	nt from Comp anization.	letely
E.	(such as, but not limited to, a	partments,	this operating entity or related to assisted living facilities, day traini- re footage, and number of beds/uni	ng facilities, day care, in	dependent l							
F.	Does this cost report reflect a		ation or pre-operating costs which	are being amortized?				YES	X NO			
1.	Total Amount Incurred:				2. Number	r of Years O	ver Which	it is Being Amor	tized:			
3.	Current Period Amortization	<del>-</del>			– 4. Dates Iı	curred:			_			
		N	ature of Costs: (Attach a complete schedule de	tailing the total amount	of organiza	tion and pre	-operating	costs.)				
XI. O	WNERSHIP COSTS:											
	A. Land.	_	1 Use	2 Square Feet	Veam	3 Acquired		4 Cost				
	A. Lailu.	-	1 FACILITY	225,000		Acquired 1994	\$	50,246	1			
			2					,	2			
		<u> </u>	3 TOTALS	225,000			8	50,246	3			

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to pearest dollar.

# 0039586 Report Period Beginning: 1/1/01 Ending:

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	B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	74		1994		\$ 2,213,241	\$ 63,235	35	\$ 63,235	\$	\$ 478,657	4
5			1994		329,317	16,465	20	16,465		124,061	5
6											6
7											7
8											8
	Impro	vement Type**	·								
		UILDING IMPROVEMENTS		1995	2,325	233	20	233		1,496	9
	UNIT HEAT			1996	642	64	20	64		346	10
	FLOORING -			1996	2,384	119	20	119		616	11
		ASEBOARD -6		1996	502	50	20	50		253	12
	DRAPES/VA			1996	3,956	396	20	396		1,980	13
	SMOKE DET	ECTORS		1996	2,880	288	20	288		1,506	14
	SIDE RAILS			1996	1,149	57	20	57		251	15
	PARKING R			1997	1,923	96	20	96		411	16
	WALL COVI	ERING		1997	897	45	20	45		211	17
	GUTTERS			1997	2,290	115	20	115		479	18
	BEAUTY SA			1997	1,040	52	20	52		222	19
	SEWER TILI			1997	1,575	79	20	79		388	20
	A/C HEATIN			1997	591	59	20	59		244	21
	WATER HEA			1997	388	19	20	19		76	22
	FLOOR PRE			1997	650	33	20	33		158	23
	FLOOR COV			1997	1,460	73	20	73		351	24
	FLOOR FINI			1997	250	13	20	13		62	25
	WATER HEA			1997	388	39	20	39		162	26
		G BATHROOM		1997	3,825	191	20	191		795	27
	CABINETS/N			1998	161	8	20	8		32	28
	HEATING/V	ENTILATING		1998	592	30	20	30		64	29
30											30
		W/ADAPTERS		1999	2,269	227	10	227		530	31
		TER LEAK - KITCHEN		2000	1,334	67	20	67		106	32
	REPAIR WA	TER LINE - BOOSTER HEATER		2000	986	49	20	49		78	33
34											34
	FROM PAGE	12.1 SUPP				69,276			(69,276)		35
36											36

See Page 12A, Line 70 for total

<sup>\*</sup>Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

# 0039586

Report Period Beginning:

1/1/01 Ending:

Page 12A 12/31/01

_	B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1	3		4	5	6	64 . 14 1 .	8	,	. 1	
		Year		<b>.</b>	Current Book	Life	Straight Line		Accumula		
	Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciati		
37	30Amp Filters, W/G System & Use Tax		\$	243	\$ 22	10	\$ 22	\$	\$	22	37
38	Wanderguard System	2001		6,263	574	10	574			574	38
39	Use Tax-Wanderguard System	2001		58	5	10	5			5	39
40	5:Thru Wall Heat/Cool Units	2001		2,131	142	5	142			142	40
41	Use Tax-5:Thru Wall Heat/Cool	2001		149	10	5	10			10	41
42	3 Ton Condenser, East Wing& Use Tax	2001		861	29	15	29			29	42
43											43
44											44
45											45
46											46
47											47
48											48
49											49
50											50
51											51
52											52
53											53
54											54
55											55
56											56
57											57
58											58
59											59
60											60
61											61
62											62
63											63
64											64
65											65
66											66
67											67
68											68
69	TOTAL (II)			2 50 ( 52 (	0 150 160		0.000	· (60.0#3			69
70	TOTAL (lines 4 thru 69)		\$	2,586,721	\$ 152,160		\$ 82,884	\$ (69,276)	\$ 614	4,317	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STATE	OF	ш	IN	OIS

Page 13 Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER 0039586 **Report Period Beginning:** 1/1/01 12/31/01 **Ending:** 

# XI. OWNERSHIP COSTS (continued)

C. 1	Equip	ment D	epreciati	ion-Exc	luding	Trans	portatio	n. (See	e instruct	ions.)	į
------	-------	--------	-----------	---------	--------	-------	----------	---------	------------	--------	---

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 419,253	\$ 42,333	\$ 42,333	\$		\$ 245,926	71
72	Current Year Purchases	6,722	865	865			865	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 425,975	\$ 43,197	\$ 43,197	\$		\$ 246,791	75

### D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

	1	L. Summary of Care-Related Assets	$\mathbf{I}$	<u> </u>				
			Reference	A	Amount			
	81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,062,942	81		
	82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	195,358	82		
Г	83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	126,082	83		
Г	84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	(69,276)	84		
	85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	861,108	85		

# F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book		Accumulated	
	Description & Year Acquired	Cost	Depreciation	3	Depreciation 4	
86	O/H ALLOCATION 1997	\$ 1,583	\$	79	\$ 270	86
87	O/H ALLOCATION 1997	568		28	91	87
88	O/H ALLOCATION 1996	277		14	64	88
89	O/H ALLOCATION 1996	965		48	196	89
90		•				90
91	TOTALS	\$ 3,393	\$	169	\$ 621	91

### G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

<sup>\*\*</sup> This must agree with Schedule V line 30, column 8.

Faci	lity Name & Il	D Number	NATURE TRA	AIL HEALTHCAF	RE CENTER	STA #	TE OF ILLINOIS 0039586		ort Period B	eginning:	1/1/01	Ending:	Page 14 12/31/01
XII.	1. Name of l 2. Does the	and Fixed Equi Party Holding		,	l amount shown below	on line	7, column 4? ]YES	]NO					
		1 Year Constructed	2 Number d of Beds	3 Date of Lease	4 Rental Amount		5 Total Years of Lease	6 Total Years Renewal Optio					
3 4 5	Original Building: Additions		0.200	254050	\$		or zense	renewar opas	3 4 5	Beginning	dates of curren	<u></u>	ment:
6	TOTAL				\$				6 7	11. Rent to b rental ag	e paid in future reement:	years under t	he current
	This amo	unt was calculangth of the leas	rtization of lease ex ated by dividing the e YES	total amount to b			*			Fiscal Yea  12. 13. 14.	/2002 /2003 /2004	Annual Rose	ent
	15. Îs Mova	ble equipment	ransportation and I rental included in I vable equipment:	building rental?	(See instructions.)  Description	n:	<u> </u>	NO le detailing the br	eakdown of	movable equipm	ent)		
	C. Vehicle Re	ental (See instr					`				Ź		
	1 Use		2 Model Year and Make		3 Monthly Lease Payment		4 Rental Expense for this Period			* If there	e is an option to	buy the buildi	ing,
17 18 19				S		\$		17 18 19			provide complet		
20								20		** This an	nount plus any a	ımortization (	of lease
21	TOTAL			\$		\$		21		expense	e must agree wit	h page 4, line	34.

Facility Name & ID Number NATURE TRAIL I		#	0039586	Report Perio	od Beginning:	1/1/01	Ending:	12/31/01		
XIII. EXPENSES RELATING TO NURSE AIDE TRAININ	G PROGRAMS (See	instructions.)				-				
A. TYPE OF TRAINING PROGRAM (If aides are tra	ined in another facilit	y program, attach a	schedule listing t	the facility	name, addre	ss and cost per	aide trained in th	at facility.)		
1 HAVE VOLUED ADDED ADDED	VEC	2 CLASSBOOM	I DODTION.			2	CLINICAL DOL	DTION.		
1. HAVE YOU TRAINED AIDES DURING THIS REPORT	YES	2. <u>CLASSROOM</u>	PORTION:			3.	CLINICAL POI	KHON:	_	
PERIOD?	X NO	IN-HOUSE PE	ROGRAM				IN-HOUSE PRO	OGRAM		
T ENGO.	110	II ( HOUSE II	to ordini	<u> </u>			II HOUSE I II	JOILLIN		
		IN OTHER FA	CILITY				IN OTHER FAC	CILITY		
If "yes", please complete the remainder										
of this schedule. If "no", provide an		COMMUNITY	COLLEGE				HOURS PER A	IDE		
explanation as to why this training was										
not necessary.		HOURS PER	AIDE							
ORIENTATION PROGRAMS ONLY										
D. EWDENGER						G G03	TED A COTALLY TO	CONT		
B. EXPENSES	ALLOCAT	TION OF COSTS	(4)			C. CO	NTRACTUAL IN	COME		
	ALLUCA	TION OF COSTS	(d)				In the box below	record the	amount of in	aama vaur
	1	2	3		4		facility received			
	<u> </u>	acility	1				racinty received	training and	es ir om othe	racinties.
	Drop-outs	Completed	Contract		Total		\$			
1 Community College Tuition	\$	\$	\$	\$			L-		<del>-</del>	
2 Books and Supplies						D. NUN	MBER OF AIDES	TRAINED		
3 Classroom Wages (a)										
4 Clinical Wages (b)							COMPLET			
5 In-House Trainer Wages (c)							1. From this faci	- 0		
6 Transportation						_	2. From other fa			
7 Contractual Payments						_	DROP-OUT	- ~		
8 Nurse Aide Competency Tests 9 TOTALS	•	(e)	•	e		<b>=</b>	1. From this faci			_
9  IUIALS	3	Ф	J)	D .		1	14. r rom otner ta	cinues (I)	1	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

TOTAL TRAINED

Page 15

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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# XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	( Cartella Services (Sactions)	1	2	3	4	5	6	7	8			
		Schedule V	Staff	f	Outside Practitioner		Outside Practitioner		Supplies			
	Service	Line & Column	Units of	Cost	(other tl	han consultant)	(Actual or)	Total Units	Total Cost			
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$ )			
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1		
	Licensed Speech and Language											
2	Development Therapist		hrs							2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist		hrs							4		
5	Physician Care		visits							5		
6	Dental Care		visits							6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
			# of									
9	Pharmacy		prescrpts		199	8,572	2,596	199	11,168	9		
	Psychological Services											
	(Evaluation and Diagnosis/											
10	Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Exceptional Care Program									12		
13	Other (specify): Audiologist					22			22	13		
14	TOTAL			\$	199	\$ 8,594	\$ 2,596	199	<b>\$</b> 11,190	14		

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

# 0039586 Report Period Beginning:
As of 12/31/01 (last day of reporting year)

XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached.

		1		2 After	
		0	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	1,052	\$	1
2	Cash-Patient Deposits		16,634		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance		476,308		3
4	Supply Inventory (priced at )		10,638		4
5	Short-Term Investments				5
6	Prepaid Insurance				6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	504,632	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		334,586		13
14	Buildings, at Historical Cost		1,176,495		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		97,149		16
17	Accumulated Depreciation (book methods)		(518,245)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -	1			
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): SEE ATTACHED SCHED 17	.1	277		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	1,090,262	\$	24
	·				
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	1,594,894	\$	25

	I	1		2 After	1
		_	perating	Consolidation*	
	C. Current Liabilities		pg		
26	Accounts Payable	\$	88,345	\$	26
27	Officer's Accounts Payable		·		27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		91,060		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		(225)		31
32	Accrued Real Estate Taxes(Sch.IX-B)		19,295		32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	SEE ATTACHED SCHED 17.1		54,297		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	252,772	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
12	Other Long-Term Liabilities(specify):				- 12
43	SEE ATTACHED SCHED 17.1		3,278,767		43
44	TOTAL TOTAL				44
4.5	TOTAL Long-Term Liabilities		2 250 575		4.5
45	(sum of lines 39 thru 44)	\$	3,278,767	\$	45
	TO THE EMPERITED		2 -21 -22		
46	(sum of lines 38 and 45)	\$	3,531,539	\$	46
47	TOTAL FOLITY/mage 10 Pro- 24)	•	(1.026.645)	6	47
4/	TOTAL EQUITY(page 18, line 24) TOTAL LIABILITIES AND EQUITY	\$	(1,936,645)	\$	4/
48	(sum of lines 46 and 47)	<b>S</b>	1,594,894	s	48
		-	-,, •	1.	

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**Ending:** 

<sup>\*(</sup>See instructions.)

0039586

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OF CI	HANGES IN EQUITY			
	-		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	(2,139,250)	1
2	Restatements (describe):	-	(=,===,===)	2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	(2,139,250)	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		202,644	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	202,644	17
	B. Transfers (Itemize):			
18	Intercompany Transfers		(39)	18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$	(39)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	(1,936,645)	24

<sup>\*</sup> This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 2,295,984	1
2	Discounts and Allowances for all Levels	(411,180)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,884,804	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,447	13
14	Non-Patient Meals	3,242	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	100	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,789	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Receipts	(34)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (34)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,896,559	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	417,146	31
32	Health Care	697,316	32
33	General Administration	440,328	33
	B. Capital Expense		
34	Ownership	80,457	34
	C. Ancillary Expense		
35	Special Cost Centers	18,153	35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,693,915	40
41	Income before Income Taxes (line 30 minus line 40)**	202,644	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 202,644	43

*	This must	t agree with	page 4,	line 45,	column 4.
---	-----------	--------------	---------	----------	-----------

*	Does this agree with	taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

<sup>\*\*\*</sup> See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,987	2,105	\$ 36,722	\$ 17.45	1
2	Assistant Director of Nursing	919	974	15,567	15.98	2
3	Registered Nurses	4,712	4,992	78,255	15.68	3
4	Licensed Practical Nurses	12,919	13,688	171,710	12.54	4
5	Nurse Aides & Orderlies	35,353	37,456	305,235	8.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	55	58		0.00	7
8	Rehab/Therapy Aides	17	17		0.00	8
9	Activity Director	1,952	2,068	18,356	8.88	9
10	Activity Assistants	1,426	1,511	9,178	6.07	10
11	Social Service Workers	1,962	2,079	20,533	9.88	11
12	Dietician					12
13	Food Service Supervisor	2,011	2,130	27,753	13.03	13
14	Head Cook	5,456	5,780	51,833	8.97	14
15	Cook Helpers/Assistants	5,406	5,728	38,195	6.67	15
16	Dishwashers					16
17	Maintenance Workers	1,989	2,107	28,262	13.41	17
	Housekeepers	7,005	7,422	51,110	6.89	18
19	Laundry	4,403	4,665	30,415	6.52	19
20	Administrator	2,011	2,130	51,161	24.02	20
21	Assistant Administrator					21
22	Other Administrative	1,952	2,068	22,818	11.03	22
23	Office Manager					23
	Clerical	162	172	1,561	9.08	24
	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	793	840	7,174	8.54	31
32	Other Health Care(specify)			,		32
33	Other(specify) Marketing	1,912	2,026	28,111	13.88	33
34	TOTAL (lines 1 - 33)	94,402	100,016	s 993,949 *	s 9.94	34

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

# B. CONSULTANT SERVICES

Report Period Beginning:

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	96	\$ 3,086	1-3	35
36	Medical Director	112	6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	149	6,732	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,137	11-3	44
45	Social Service Consultant	36	1,617	12-3	45
46	Other(specify)				46
47					47
48					48
	· · · · · · · · · · · · · · · · · · ·				
49	TOTAL (lines 35 - 48)	429	s 18,572		49

# C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

<sup>\*\*</sup> See instructions.

STATE	OF	HI	JIN	OI

Page 21 Ending: 12/31/01 Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER # 0039586

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER					# 0039586 Report Period B				inning: 1/1/01 Ending: 12			
XIX. SUPPORT SCHEDULES												
A. Administrative Salaries Ownership			)		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%		Amount	Description			Amount		Description		Amoun
teven L. Johnson	Administrator	0	\$_	57,619	Workers' Compensation Insurance		\$	25,945	IDPH Lice			3
			_		Unemployment Compensation Ins	surance	_	12,569		g: Employee Recruitment		
			_		FICA Taxes		_	73,516		re Worker Background Cl	ieck	
			_		<b>Employee Health Insurance</b>			64,470	(Indicate #	of checks performed	)	
			_		<b>Employee Meals</b>		_					
			_		Illinois Municipal Retirement Fur	nd (IMRF)*			Dues			4,0
	<u> </u>		_		Other Employee Benefits			2,761		-		
TOTAL (agree to Schedule V, line 17, col. 1)			_					<u> </u>	<b>Home Office</b>	e Allocation		
List each licensed administrator	separately.)		\$	57,619								
B. Administrative - Other							_					
							_		Less: Pub	lic Relations Expense	_ (	
Description				Amount			_		Non	-allowable advertising	— ; ·	
•			\$				_			ow page advertising	— ; ·	
			-				_			··· puga maranang	`	
			_	-	TOTAL (agree to Schedule V,		\$	179,261		TOTAL (agree to Sch. V	\$	4,4
					1 TOTAL (agree to Schedule V.							
			-		, ,		Ψ=	177,201		, 0		
FOTAL (agree to Schedule V. lin	e 17. col. 3)		- S		line 22, col.8)	sation Paid	=	177,201	G. Schedu	line 20, col. 8)	:	
,	, ,	<u> </u>	\$_		line 22, col.8) E. Schedule of Non-Cash Compen	nsation Paid		177,201	G. Schedu	, 0	:	-, -
Attach a copy of any managemen	, ,	)	\$_		line 22, col.8)	sation Paid		177,201	G. Schedu	line 20, col. 8) le of Travel and Seminar*	:	,
Attach a copy of any management C. Professional Services	nt service agreement)	)	\$_	Amount	line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees		=		G. Schedu	line 20, col. 8)	:	,
Attach a copy of any management. Professional Services Vendor/Payee	nt service agreement)  Type	)	\$_ 	Amount	line 22, col.8) E. Schedule of Non-Cash Compen	nsation Paid Line #	-	Amount		line 20, col. 8) le of Travel and Seminar*  Description	÷	Amour
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Attach a copy of any management. Professional Services Vendor/Payee	nt service agreement)  Type	)	\$_ \$_		line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees		\$_ 		Out-of-Sta	line 20, col. 8) le of Travel and Seminar*  Description te Travel	÷	Amour
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Attach a copy of any management. Professional Services Vendor/Payee	nt service agreement)  Type	)	\$_ \$_ 		line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees		\$		Out-of-Sta	line 20, col. 8) le of Travel and Seminar*  Description te Travel	÷	Amour
Attach a copy of any management. Professional Services Vendor/Payee	nt service agreement)  Type	)	\$_ \$_		line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees		\$_ - - -		Out-of-Sta	line 20, col. 8) le of Travel and Seminar*  Description te Travel	÷	Amour
Attach a copy of any management. Professional Services Vendor/Payee	nt service agreement)  Type	)	\$_ \$_ 		line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees		\$ 		Out-of-Sta  In-State Ti  Home Office	line 20, col. 8) le of Travel and Seminar*  Description  te Travel  ravel  ce Allocation	÷	Amoui
Attach a copy of any management. Professional Services Vendor/Payee	nt service agreement)  Type	)	\$_ \$_ \$		line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees		\$ 		Out-of-Sta	line 20, col. 8) le of Travel and Seminar*  Description  te Travel  ravel  ce Allocation	÷	Amour
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Attach a copy of any management. Professional Services Vendor/Payee	nt service agreement)  Type	)	\$ = \$  		line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees		\$		Out-of-Sta  In-State Ti  Home Office	line 20, col. 8) le of Travel and Seminar*  Description  te Travel  ravel  ce Allocation	÷	Amoun
Attach a copy of any management. Professional Services Vendor/Payee	nt service agreement)  Type		\$		line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees		\$		Out-of-Sta  In-State Ti  Home Office  Seminar E	line 20, col. 8) le of Travel and Seminar*  Description  te Travel  ravel  ravel  e Allocation  xpense	÷	Amour
Attach a copy of any management. C. Professional Services Vendor/Payee Legal Fees	Type Legal Fees		\$		line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees  Description		\$		Out-of-Sta  In-State Ti  Home Office  Seminar E	line 20, col. 8) le of Travel and Seminar*  Description  te Travel  ravel  ee Allocation  xpense	÷	Amour
FOTAL (agree to Schedule V, lin (Attach a copy of any managemer C. Professional Services Vendor/Payee Legal Fees	Type Legal Fees		\$		line 22, col.8)  E. Schedule of Non-Cash Compento Owners or Employees		\$ 		Out-of-Sta  In-State Ti  Home Office  Seminar E	line 20, col. 8) le of Travel and Seminar*  Description  te Travel  ravel  ravel  e Allocation  xpense	÷	Amoun

<sup>\*\*</sup>See instructions.

STATE	OF	ILLINOIS

Page 22 12/31/01 Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER Report Period Beginning: Ending: 1/1/01 0039586

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

20

TOTALS

(See instructions.)												
1		3	4	5	6	7					12	13
Improvement	Improvement	Total Cost										
Туре	Was Made		Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
		1 2 Month & Year Improvement Improvement	1         2         3           Month & Year         Improvement         Total Cost	1 2 3 4  Month & Year Improvement Improvement Was Made Total Cost Useful Life	1 2 3 4 5  Month & Year Improvement Type Was Made Total Cost Useful Life FY1998	1         2         3         4         5         6           Improvement Type         Improvement Was Made         Total Cost Tot	1         2         3         4         5         6         7           Improvement Type         Improvement Was Made         Total Cost Useful Life         Useful FY1998         FY1999         FY2000	1   2   3   4   5   6   7   8	1   2   3   4   5   6   7   8   9	1         2         3         4         5         6         7         8         9         10           Month & Year Improvement Type         Total Cost Was Made         Useful Life         FY1998         FY1999         FY2000         FY2001         FY2002         FY2003	1   2   3   4   5   6   7   8   9   10   11	1     2     3     4     5     6     7     8     9     10     11     12       Improvement Type     Was Made     Total Cost     Useful Life     FY1998     FY1999     FY2000     FY2001     FY2002     FY2003     FY2004     FY2005

Facilit	y Name & ID Number NATURE TRAIL HEALTHCARE CENTER		OF ILLINOIS # 0039586	Report Period Beginning:	1/1/01	Ending:	Page 23 12/31/01
	ENERAL INFORMATION:	7.	0037300	Report I criou Beginning.	1/1/01	Ending.	12/31/01
	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		plies and services which are of the blic Aid, in addition to the daily ra			
(2)	Are there any dues to nursing home associations included on the cost report? YES If YES, give association name and amount.  ILLINOIS HEALTHCARE ASSOCIATION		in the Ancillary Section	on of Schedule V? YES	_		
(3)	Did the nursing home make political contributions or payments to a political action organization?  NO  If YES, have these costs been properly adjusted out of the cost report?	(14)	the patient census list is a portion of the bui	lding used for any function other the don page 2, Section B? NO lding used for rental, a pharmacy, lains how all related costs were all	day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  NO If YES, what is the capacity?	(15)	Indicate the cost of er on Schedule V. related costs?		ssified to emplo meal income be the amount. \$	een offset aga	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases?  What was the average life used for new equipment added during this period?  YES  10	(16)	Travel and Transporta	ation	NO		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ Line		If YES, attach a co	mplete explanation.  arate contract with the Department  If YES, please indicate the a	to provide med		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  YES  If NO, attach a complete explanation.			s reporting period. \$ travel expense relates to transporte logs been maintained? N/A	ation of nurses	and patients'	?0
(8)	Are you presently operating under a sale and leaseback arrangement? YES If YES, give effective date of lease.		e. Are all vehicles sto times when not in t	red at the nursing home during the	•		
(9)	Are you presently operating under a sublease agreement? YES X NO	)	out of the cost repo		_		NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facilit IDPH license number of this related party and the date the present owners took over.	y,	Indicate the amo	ount of income earned from polying this reporting period.		n Ö	
		(17)	Firm Name:	formed by an independent certified	•	The instruct	tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		cost report require that been attached?	at a copy of this audit be included with the inc	vith the cost rej	port. Has thi	s copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.	,	out of Schedule V?	do not relate to the provision of lot YES		· ·	
		(19)	performed been attack	in excess of \$2500, have legal involved to this cost report?  N/A summary of services for all archit		Ĭ	ices